Cancer Detection Programs: Every Woman Counts

RECIPIENT ELIGIBILITY FORM
FORM A

Top section to be completed by patient

Patient name_____ Date of birth_____

Income

Total number of family members living together (applicant, spouse, children aged 20 and younger): ☐

Total gross monthly income of family members: ☐

Health Insurance

I have no health insurance: ☐ None

I have this kind of health insurance:
- ☐ Medi-Cal
- ☐ Military
- ☐ Private insurance
- ☐ Medicare Part B
- ☐ Family PACT
- ☐ Other _____

I certify that the above information is correct and complete:

_____ _____
Patient Signature Date Signed

PROVIDER USE ONLY Eligibility Checklist

Supporting documentation on file establishes that recipient:

☐ Meets program's age criteria for breast and cervical cancer screening and diagnostic programs.
[≥ 40 years of age for Breast Services or ≥ 25 years of age for Cervical Services]

☐ Meets program's income and insurance criteria for breast and cervical cancer screening and diagnostic programs.
[≤ 200% Federal Poverty Level; Payor of Last Resort: Unmet Share Of Cost, Unmet deductible, Exhausted Family PACT, No Medicare Part B]

☐ Recipient referred for Breast and Cervical Cancer Treatment Program (Optional).

☐ Signed program's consent form.

I have determined that this woman is eligible for CDP services *.

_____ _____
Primary Care Provider Staff Certifying Signature Date Certified

To be eligible for program participation, clients must meet age, income and health insurance criteria. All three must be met for eligibility.

**Eligibility determination policies and information are located in the CDP Section of the Medi-Cal Manual*.

Complete all fields. Place original in patient chart.
ELIGIBILITY FORM A (1/03)